

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE **Physical Therapy Re-Evaluation Form** Neck Pain

OTSG APPROVED (Date)

- Is Physical Therapy helping to increase your ability to function or decrease your pain/symptoms? ☐ Yes ☐ No
- Symptoms are? ☐ Increasing ☐ Unchanged ☐ Decreasing
- Symptoms are? ☐ Constant ☐ Come/Go ☐ Only with Activity
- Medication Use? ☐ Increasing ☐ Decreasing ☐ Not Helping ☐ Not taking

Mark an "X" on the lines below that best describes your response.

1. What activity causes the most pain / have most trouble performing?

Function: Rate your ability to perform the *above* activity.

0	1	2	3	4	5	6	7	8	9	10	
Unable to Perform											No restrictions

2. Pain at WORST: Rate your highest level of pain in past 72 hrs.

0	1	2	3	4	5	6	7	8	9	10	
No pain											Worst pain Imaginable

3. Pain at BEST: Rate you lowest level of pain in past 72 hrs.

0	1	2	3	4	5	6	7	8	9	10	
No pain											Worst pain Imaginable

Indicate the location and type of pain on the chart:

Key:

Ache/Dull: ^ ^ ^ ^

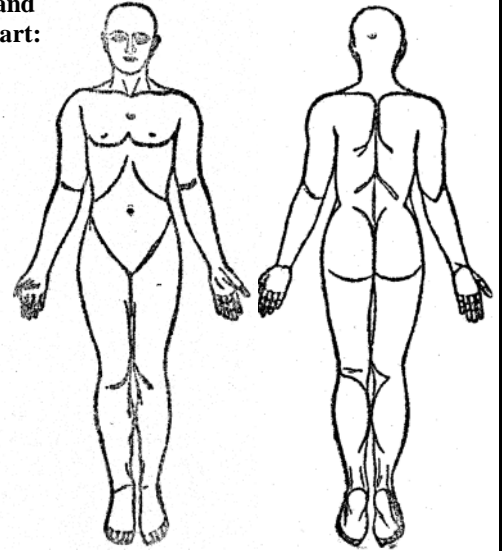
Sharp/Stabbing: x x x x

Numb / Tingling:

Burning: = = = =

Throbbing: / / / /

Other Pain: - - - -



PATIENT SIGNATURE / PREPARED BY:

DATE

Provider Notes:

- ☐ See digital PT progress note in CHCS
- ☐ Patient ed. Completed. Patient verbalizes understanding and concurs with revised plan of care.

REVIEWED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
LRMC Physical Therapy
APO AE 09180 486-8263

DATE

PATIENTS IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; rank; hospital or medical facility)

NAME (Last, First MI):

FMP / SSN (Sponsor): /

GRADE or RANK:

DOB:
(Patients, dd-mmm-yyyy)

- | | |
|---|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input checked="" type="checkbox"/> OTHER/EXAMINATION
OR EXAMINATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

DA FORM 4700
1 MAY 78

MCEUH OP 370-R, APR 96(Rev)
DA 4700 Medical Hx Follow Up Form - PFI update 7.doc, Updated 13-May-11

NECK DISABILITY INDEX¹

Section 1: To be completed by patient

_____ AD _____ Non-Active Duty

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of days of neck pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your neck pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

Pain Intensity

- _____ I have no pain at the moment.
- _____ The pain is very mild at the moment.
- _____ The pain is moderate at the moment.
- _____ The pain is fairly severe at the moment.
- _____ The pain is very severe at the moment.
- _____ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

- _____ I do not have to change the way I wash and dress myself to avoid pain.
- _____ I do not normally change the way I wash or dress myself even though it causes some pain.
- _____ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- _____ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- _____ Because of my pain I am partially unable to wash and dress without help.
- _____ Because of my pain I am completely unable to wash or dress without help.

Lifting

- _____ I can lift heavy weights without increased pain.
- _____ I can lift heavy weights but it causes increased pain
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- _____ Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
- _____ I can lift only very light weights.
- _____ I can not lift or carry anything at all.

Reading

- _____ I can read as much as I want to with no pain in my neck.
- _____ I can read as much as I want to with slight pain in my neck.
- _____ I can read as much as I want with moderate pain in my neck.
- _____ I can't read as much as I want because of moderate pain in my neck.
- _____ I can hardly read at all because of severe pain in my neck.
- _____ I cannot read at all.

Headache

- _____ I have no headache at all.
- _____ I have slight headaches which come infrequently.
- _____ I have moderate headaches which come infrequently.
- _____ I have moderate headaches which come frequently.
- _____ I have severe headaches which come frequently.
- _____ I have headaches almost all the time.

(Don't forget to fill out the back side)

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Section 2 (con't): To be completed by patient

Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Work

- ☐ I can do as much as I want to.
- ☐ I can only do my usual work but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleep loss).
- ☐ My sleep is mildly disturbed (1-2 hour sleep loss).
- ☐ My sleep is moderately disturbed (2-3 hours sleep loss).
- ☐ My sleep is greatly disturbed (3-5 hours sleep loss).
- ☐ My sleep is completely disturbed (5-7 hours sleep loss).

Recreation

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

Section 3: To be completed by physical therapist/provider

SCORE: _____ out of 50 (SEM 5, MDC 7)

Initial **F/U** ____ **weeks** **Discharge**

Number of treatment sessions: _____

Gender: Male Female

Diagnosis/ICD-9 Code: _____

¹ Adapted from Vernon H, Mior S. The Neck Disability Index: A Study of Reliability and Validity. Journal of Manipulative and Physiological Therapeutics 1991; 14(7): 409-415.